Good morning. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley. The American Society of Anesthesiologists (ASA) is an educational, research, scientific, and standard-setting organization for the medical specialty of anesthesiology. On behalf of our more than 56,000 members, I thank the Subcommittee for convening this important hearing on *"VA's Federal Supremacy Initiative: Putting Veterans First?"*.

We are pleased that the Committee has appropriately focused this issue on the prioritization of the best interests of our nation's Veterans. ASA is committed to Veterans and believes the physician-led anesthesia care team model provides the best care to our nation's Veterans. It is what they have earned and deserve. This issue is not about what ASA wants or even what the VA Office of Nursing Services wants. The issue is what is best for the health and well-being of the nation's Veterans, including the new PACT Act Veterans.

The evidence supports that Veterans' health is best served by the VA's existing, proven physician-led anesthesia team-based model of care – a model that recognizes the medical expertise of physicians, and the nursing education and experience of certified registered nurse anesthetists (CRNAs). This model of care assures our nation's Veterans will continue to have access to safe, high quality anesthesia care – the same standard of care used in every top civilian hospital.

We ask the Subcommittee to urge the Department of Veterans Affairs to reject changes proposed by the VA Office of Nursing Services that would lower the standard of care for Veterans by dismantling the team-based model of care and permit a CRNA-only model of anesthesia. The proposal needlessly places the health and lives of Veterans at risk.

We are not here today to challenge the important role that CRNAs play in caring for Veterans. ASA is not trying to change the current practice of VA nurse anesthetists. CRNAs currently practice in VA with our VA anesthesiologists. ASA endorses the existing, **proven** team-based model of care used throughout the VA system, as well as throughout our nation's civilian facilities. This is about whether VA will keep anesthesiologists involved in the teams that provide needed surgical care to Veterans, receiving complex surgical and procedural care.

Key Points

- **Anesthesia is a complex and challenging practice of medicine, posing significant potential patient risks, particularly for the large number of Veterans with underlying health conditions, particularly PACT Act Veterans.**

- **Veterans should have the same standard of care as non-Veterans; they have certainly earned that right.**

- **Anesthesiologists and nurse anesthetists are not interchangeable health care professionals. The education and training of physician anesthesiologists and nurse anesthetists differ dramatically. ASA has many members who formerly trained and practiced as CRNAs before choosing to complete their comprehensive medical education and training to become anesthesiologists.**

- **VA's current anesthesia policy is one of the most thoroughly researched, studied, and reviewed policies existing in VA. The current policy, Anesthesia Services Directive 1123, represents a safe, well-established, and functional compromise approach to anesthesia care delivery. No changes are clinically appropriate or necessary.**

- **There is no demonstrated shortage of anesthesia clinicians necessitating a change in the delivery of anesthesia care within the Department of Veterans Affairs.**

- **VA patients are not the same as Department of Defense patients.**

- **There is no unbiased literature to support the safety of eliminating physician clinical oversight of anesthesia. To the contrary, <u>independent</u> literature points to the risk to patients of anesthesia without appropriate physician clinical oversight.**

<u>Background</u>

VA is leading an initiative known as the Federal Supremacy/National Standards of Practice[1] (NSP) initiative. Under the initiative, VA is seeking to "standardize the practice" of nearly 50 VA health occupations. The standards would apply to all VA facilities, regardless of state law. After the standards are approved, they will be issued as VA Directives.

VA currently has an existing anesthesia standard and directive, VA National Anesthesia Service, VHA Directive 1123[2], which was finalized in October of 2019. The Directive took over 6 years to develop and is one of VA's most thoroughly researched and vetted standards in existence. The process began in 2013 and included two public comment periods generating a department record of 200,000 comments[3]. A final rule was issued in December of 2016[4]. VA got it right in its 2016 rulemaking when it prioritized the needs of Veterans and maintained the physician-led anesthesia care team model; the gold standard that is enjoyed by civilians across the country. Three more years of work were completed before the issuance of the final Anesthesia Directive on October 24, 2019.

The standard affirmed VA's longstanding policy that, "The possible maximum breadth of Certified Registered Nurse Anesthetist (CRNA) practice is controlled by the individual's State license." In 45 states, CRNAs providing anesthesia must have some degree of clinical oversight by a physician. This is frequently referred to as the anesthesiologist/CRNA Anesthesia Team model.

<u>Anesthesia is a complex and challenging practice of medicine, posing significant potential patient risks, particularly for the large number of Veterans with underlying health conditions, particularly PACT Act Veterans.</u>

Physician-led anesthesia care is the essential model of care for Veterans, especially those who have been toxin-exposed and face a higher risk of complications under anesthesia.

The poorer overall health status of the general Veteran population is well-documented in medical literature.[5] Multiple peer-reviewed studies have proven that VA patients have poorer health status, such

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[1] *VA National Standards of Practice:* U.S. Department of Veterans Affairs. <u>www.va.gov/standardsofpractice</u>. Accessed May 10, 2023.

[2] *National Anesthesia Service: VHA Directive 1123,* U.S. Department of Veterans Affairs, Washington, D.C.: October 24, 2019. Amended April 17, 2023.

[3] *VA Grants Full Practice Authority to Advance Practice Registered Nurses: Decision Follows Federal Register Notice That Netted More Than 200,000 Comments*. News Release. U.S. Department of Veterans Affairs, Washington, DC: December 14, 2016.

[4] *Advanced Practice Registered Nurses.* Final Rule, 81 FR 90198. U.S. Department of Veterans Affairs, Washington, D.C.: December 14, 2023. 90198-90207

[5] *Eibner C, Krull H, Brown K, et al. "Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs." Santa Monica, CA: RAND Corporation, 2015. Page xxvi*

as diabetes, congestive heart failure, atherosclerotic coronary and peripheral vascular disease, hepatic failure, renal failure, and chronic obstructive pulmonary disease. These comorbidities and underlying chronic conditions, many of which are service-related, put Veterans at significant risk during surgery.[6, 7] Life-threatening situations can occur unpredictably, and a physician's leadership, knowledge, and expertise reduce those risks.

Most noteworthy, with the enactment of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, Congress recognized many of the underlying conditions that can make anesthesia a higher risk for Veterans who have been exposed to Agent Orange, Burn Pits, and other toxic substances: asthma; chronic bronchitis; chronic obstructive pulmonary disease (COPD), and others. Toxic-exposed Veterans require an **even higher** level of care under anesthesia. Agent Orange-related Parkinson's Disease is directly tied to surgery-related risk, including significant interactions between anesthetic medications and Parkinson's Disease medications.[8] Further, general anesthesia is known to cause adverse outcomes in patients with COPD, including those with Burn Pit related COPD.[9][10][11]

It makes no sense for VA to spend billions of dollars to treat the respiratory disease of our PACT Act Veterans only to put those same Veterans at greater risk in the operating room by adopting the nurse-only model of anesthesia.

Veterans should have the same standard of care as non-Veterans; they have certainly earned that right, not a lower standard.

VA is proposing to impose a standard of practice on VA facilities that is inconsistent with the standard applicable to non-VA facilities. Specifically, VA intends to impose the rarely used CRNA-only standard on VA facilities, regardless of state law. Because the CRNA-only model is not permitted in most states, VA would be exercising its discretionary authority to disregard state law. The action will create conflicting standards of care in most states.

Currently, forty-five states require that a nurse anesthetist provide anesthesia with various levels of physician involvement. Many states define the physician's role as "supervision," either in state law or through Medicare's supervision requirement. Other states utilize terminology such as physician "direction," "collaboration," "approval," or "consultation."

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[6] Garshick E, Blanc PD. *Military deployment-related respiratory problems: an update*. Curr Opin Pulm Med. Epub 2023 Jan 4.

[7] Zhao H, Li L, Yang G, Gong J, Ye L, Zhi S, Zhang X, Li J. *Postoperative outcomes of patients with chronic obstructive pulmonary disease undergoing coronary artery bypass grafting surgery: A meta-analysis.* Medicine (Baltimore). 2019 Feb.

[8] *Shaikh, S. I., & Verma, H. "Parkinson's disease and anaesthesia." Indian Journal of Anaesthesia, 55(3), 228–234. May-June 2011.*

[9] *Andrew Lumb, MBBS FRCA, Claire Biercamp, MBChB FRCA, "Chronic obstructive pulmonary disease and anaesthesia." Continuing Education in Anaesthesia Critical Care & Pain, Volume 14, Issue 1, Pages 1–5, February 2014.*

Anesthesiologists and nurse anesthetists are not interchangeable health care professionals. The education and training of physician anesthesiologists and nurse anesthetists differs dramatically. ASA has many members who formerly trained and practiced as CRNAs before choosing to complete their more comprehensive medical education and training to become anesthesiologists.

First and foremost, it is critical to remember that physician anesthesiologists and nurse anesthetists are not interchangeable – physician anesthesiologists bring a unique capacity to safely provide anesthesia care to the full range of patients. These critical capacities are gained through four years of comprehensive medical school training following an undergraduate education, then four additional years of rigorous residency training, during which an authoritative understanding of the human body and its systems is derived not only from didactic sessions but more importantly from hundreds of increasingly complex clinical interactions with patients. I have spent most of my career teaching and training medical students and residents in the medical specialty of anesthesiology. Although nurse anesthetists are truly outstanding nurse practitioners, I can attest that the foundational knowledge of science and medicine gained by physician anesthesiologists yields a depth and breadth of understanding of the intricate complexities of perioperative patient care that is well beyond the training and education provided to nurse anesthetists.

All told, a physician's education and training include 12 to 14 years following high school, including medical school and residency, and 12,000 to 16,000 hours of clinical training. In contrast, a nurse anesthetist's education and training ranges from 4 to 6 years after high school – less than half a physician's training and an average of approximately 2,000 hours of patient care training – less than one-sixth that of physicians. 45 states across the country continue to require some level of physician involvement with nurse anesthetists during surgery – there is simply no replacement for a physician's expertise.[12]

Nurse anesthetists are trained to work within the physician-led care team and with physician involvement. All nurse anesthetists' education programs, except one in Oregon, are in states that require physician clinical oversight of nurse anesthetists. Thus, the vast majority of nurse anesthetists are neither educated nor trained to practice in the nurse-only model. Overall, their nursing-based training, with its limited classroom duration and fewer hours of clinical training, does not allow for detailed, comprehensive medical knowledge.

It is not surprising, then, that 45 states do not permit the nurse-only model of anesthesia that VA has proposed in its Federal Supremacy Initiative. In fact, not one of the top-ranked civilian hospitals in the country employs this untested model. **Not one**. It would be wrong to give Veterans a lower standard of care than what civilians routinely receive across the country, especially because Veterans are a unique population who presents distinct medical challenges.

VA's current anesthesia policy is one of the most thoroughly researched, studied, and reviewed policies existing in VA. The current policy, Anesthesia Services Directive 1123, represents a safe, well-established, and functional compromise approach to anesthesia care delivery. No changes are clinically appropriate or necessary.

The final product for the National Standards of Practice process is a Directive. A national directive for anesthesia already exists in Directive 1123. Directive 1123 is the product of the 2017 APRN final rule which included years of extensive research and two record-breaking Federal Register public comment periods. VA concluded that there was no shortage of anesthesiologists in its system and insufficient data to support the nurse-only model. The findings were not the same for the primary care APRNs -- Nurse Practitioners, Clinical Nurse Specialists and Nurse Midwives. The result of the 2017 APRN final rule was two directives: one for primary care APRNs, Directive 1350; and one for Anesthesia, Directive 1123. VA should recognize Directive

[12] Department of Veterans Affairs, Veterans Health Agency, National Anesthesia program

1123 as the National Standard of Practice for CRNAs, just as VA is recognizing Directive 1350 as the National Standard of Practice for primary care APRNs. To do otherwise is fundamentally inconsistent.

There is no demonstrated shortage of anesthesia clinicians necessitating a change in the delivery of anesthesia care within the Department of Veterans Affairs. Removing anesthesiologists from the care of our Veterans risks creating the very workforce shortage this proposal is claiming to solve.

ASA has closely tracked vacancies for physician anesthesiologists for over 4 years through USAJOBS.gov, the official employment website for the federal government. According to USAJOBS.gov, on September 14, 2023, the number of openings for physician anesthesiologists numbered 31 throughout the entire country, or a job openings rate of 2.9%, which is at or below a typical vacancy rate for such professionals, reflecting normal turnover that occurs in anesthesiologist positions in VA. There is no shortage of physician anesthesiologists in VA, and no evidence of access issues associated with anesthesia care that would necessitate a change in clinical oversight of nurse anesthetists and in the delivery of anesthesia to meet patient demand.

VA patients are not the same as Department of Defense patients. VA has often suggested that it wishes to adopt Department of Defense standards of care. That is not advisable. Active-duty service members have very different health needs than our Nation's Veterans. Naturally, active-duty troops tend to be much younger than Veterans: they are fit, they have fewer comorbidities, they have not yet had concerning occupational exposures, and they are subject to regular fitness tests and rigorous health screenings. Their risks when undergoing anesthesia, therefore, tend to be much lower than a sick Veteran who receives treatment in a VA hospital, oftentimes decades after their service.

Even so, the United States military recruits and retains anesthesiologists. In many cases, the military utilizes the internationally recognized and mandated anesthesia care team (ACT) model within military hospitals and Military Treatment Facilities (MTFs). Every branch of the military employs and counts on physician anesthesiologists.

There is no unbiased literature to support the safety of eliminating physician clinical oversight of anesthesia. To the contrary, independent literature points to the risk to patients of anesthesia without appropriate physician clinical oversight.

VA's current policies promoting team-based models of anesthesia care ensure Veteran access to safe, high-quality anesthesia services. Because these policies are so important to Veteran patient care, any change in policy being considered should be preceded by the collection of extensive and rigorous independent, scientifically valid evidence that supports the safety of anesthesia care outside of the team-based model. As VA's own assessment concluded, such evidence does not exist. Indeed, available independent evidence indicates patients are best served by some level of clinical oversight of anesthesia by a physician. To this point, in the 2022 Burns et al study in *JAMA Surgery,* researchers found that "as **physician anesthesiologist clinical oversight of CRNAs is lessened, patients experience higher rates of injury or death**."[13]

ASA commends VA for utilizing its own research resources to investigate the quality-of-care implication of anesthesia delivered by a nurse anesthetist outside of a team-based model. VA's Quality Enhancement Research Initiative (QUERI), conducted an evidence review of available literature "to assess the strength and relevance of studies comparing autonomous APRNs with physicians in primary care, urgent care and anesthesia settings for 4 important outcomes: health status, quality of life, hospitalizations, and mortality."

With regard to anesthesia, the September 2014 QUERI document, "Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses," found that the evidence to support full practice authority related to nurse anesthetists was "insufficient" and at "high risk of bias."8The paper stated that "[t]he results of these studies do not provide any guidance on how to assign patients for management by a solo CRNA, or whether

[13] *Burns et al. Association of Anesthesiologist Staffing Ratio with Surgical Patient Morbidity and Mortality. JAMA Surg 2022 (July).*

more complex surgeries can be safely managed by CRNAs, particularly in small or isolated VA hospitals where preoperative and postoperative health system factors may be less than optimal."[14] ASA urges VA to give full consideration to the document's findings, particularly the findings that question whether complex cases can be safely managed by nurse anesthetists outside of the team-based model of care. The VA's review clearly raises questions regarding the ability of the solo nurse anesthetist model to safely manage complex patient cases.

The QUERI assessment references Silber 2000, which remains one of very few independent anesthesia outcomes studies. ASA encourages consideration of this study, titled, "Anesthesiologist Direction and Patient Outcomes," in which the relationship between physician direction and patient outcomes is analyzed. In any study, it is difficult to determine the effect of anesthesia providers on patient outcomes because of the myriad factors that can influence a patient's outcome. However, the authors of this study use robust risk-adjustment techniques that greatly improve the validity of their conclusions. This study should inform responsible policy decision-making in the future when comparing anesthesia providers. The study found the odds of death to be 8 percent higher and the odds of failure-to-rescue to be 10 percent higher in cases where the administration of anesthesia was not directed by a physician anesthesiologist. This corresponds to 2.5 excess deaths per 1,000 patients and 6.9 excess failures-to-rescue per 1,000 patients with complications. The authors employ a wide array of risk adjustment methods and multiple statistical analyses to fortify the validity of their conclusions. Such a statistically sound and conclusive study should be considered when making policy decisions about scope of practice for anesthesia providers.[15]

QUERI notes that Silber's "comparison group does not directly represent care provided by an independent CRNA." That statement is true; however, ASA would point out that QUERI's criticism helps illustrate the strength of the study's results. As indicated, Silber's "undirected" group includes nurse anesthetists practicing independently, plus nurse anesthetists working in non-direction team-based models with physician anesthesiologists and other physicians. Accordingly, it is very likely that the outcomes differences presented by Silber understate the true effect of anesthesiologist involvement on patient outcomes.

QUERI also comments about Silber's risk adjustment methods, noting that "undirected cases were performed in smaller hospitals and hospital size does not adequately explain differences" in outcomes. Much like the comparison group issue, this criticism indicates a likely understatement of the positive impact provided by anesthesiologist care. If undirected cases were performed in smaller hospitals and hospital size does not adequately explain the differences in outcomes, then ideal risk adjustment likely would have resulted in differences even larger than Silber reported. ASA urges review of Silber with these comments in mind as it considers the patient safety implications of the application to nurse anesthetists.

After consideration of the VA QUERI review, a December 14, 2016 final rule did not eliminate the physician oversight requirement of nurse anesthetists from VA's policies. VA eliminated the oversight requirements for all other categories of advanced practice registered nurses (APRN) but explicitly excluded nurse anesthetists. "The final rulemaking establishes professional qualifications an individual must possess to be appointed as an APRN within VA, establishes the criteria under which VA may grant full practice authority to an APRN and defines the scope of full practice authority for each of the three roles of APRN. Certified Registered Nurse Anesthetists will **not** be included in VA's full practice authority under this final rule"[16] [emphasis from original].

Subsequently, the *National Bureau of Economic Research* published in 2022 a study of VA's own emergency department visits between January 2017 and January 2020, the period in which nurse practitioners were first authorized by the VHA to practice in the nurse-only model, without physician supervision. VA's data revealed that emergency care provided by nurse practitioners (NPs) increased costs, utilized more services and lowered the quality of care.[17]

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[14] *U.S. Department of Veterans Affairs, Health Services Research and Development Services, "Evidence Brief: Quality of Care Provided by Advanced Practice Nurses, September 2014*
[15] *Silber JH, et al. Anesthesiologists direction and patient outcomes. Anesthesiology. Jul 2000.*
[16] *U.S. Department of Veteran Affairs, Press Release, VA Grants Full Practice Authority to Advance Practice Registered Nurses, December 14, 2016*
[17] *Chan, D. and Chen, Y. "The Productivity of Professions: Evidence from the Emergency Department," National Bureau of Economic Research (NBER), October 2022.*

ASA also urges consideration of the 2012 study titled “Factors influencing unexpected disposition after orthopedic ambulatory surgery.” In the outpatient setting, patients are expected to undergo a relatively low-risk surgery and be discharged to their place of residence on the same day. Any other outcome was considered an “unexpected disposition.” In this study of ambulatory surgery by Memtsoudis et al., the researchers found, among other results, that the odds of “unexpected disposition” after ambulatory surgery were 80 percent higher when the anesthesia care was provided by only a nurse anesthetist as opposed to a physician anesthesiologist. Unexpected dispositions may occur due to the patient experiencing an unanticipated adverse outcome from their procedure or anesthesia care, which may also result in additional costs to payers. The Memtsoudis study illustrates that even for low-risk procedures such as ambulatory knee and shoulder surgery, physician anesthesiologists achieve better outcomes than nurse anesthetists practicing outside of the team-based model of care.[18]

Conclusion

The physician-delivered and physician-led anesthesia care team model puts the health and safety of Veterans first. Dismantling or altering this model will subject Veterans to a lower standard of care than civilians receive. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, thank you for your time and attention to this issue which is integral to the health and lives of Veterans. I welcome your questions.

[18] *Memtsoudis SG, et al. Factors influencing unexpected disposition after orthopedic ambulatory surgery. Journal of Clinical Anesth, 2012.*